ONE POINT

MEDICAL

Name of patient(s): _____ D.O.B. _____

_____ D.O.B. _____

I authorise for a copy of all my records to be forwarded to the above clinic.

Signature of Patient(s): _____

_____

Patients aged 16yrs and over must sign individually

Date: _____

Name of previous Doctor/ Specialist: _____

Address of previous Doctor: _____

_____

_____

Postcode _____

Phone number _____

Fax Number_____

Dear Doctor

This patient will now/also be attending this clinic under our care. We would appreciate if you would forward a copy of his/her medical records**. If you use Medical Director, please provide on disc in .xml format. For all other software we would appreciate receiving the records in .pdf**

Yours sincerely

Dr Chris Mulroney Dr Sophie Macneil Dr Juliet Froomes

Dr Ilana Hornstein Dr Joel Chan

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